Written evidence submitted by the Health Foundation (PHP0100)

1. Introduction

1.1. Thank you for the opportunity to respond to the Health Select Committee’s inquiry on public health. Our submission provides analysis on public health funding, how health outcomes and public health services (e.g., screening and vaccinations) compare internationally and the opportunities presented by devolution.

2. About the Health Foundation

2.1. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

2.2. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

2.3. We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people’s skills and knowledge, we aim to make a difference and contribute to a healthier population.

3. Context

The importance of public health to the NHS Five Year Forward View

3.1. The NHS Five Year Forward View called for a radical upgrade in prevention, and support for wider public health measures. Given the funding pressures in the Department of Health and local authority-financed public health services and the need for wider government action on obesity and related challenges, this has not yet been delivered. It is yet to be seen whether the government’s proposed childhood obesity strategy comprises an effective package of credible actions when it is published in the new year. Without this, and other linked action, the NHS will be exposed to increasing patient demand and consequent funding pressures over and above that modelled in the Five Year Forward View assumptions.

3.2. There is an implicit recognition in the Five Year Forward View that the NHS cannot, and arguably should not, do everything that’s needed by itself. The vision described by NHS England sets out the need to prevent ill-health and promote healthy behaviours with targeted programmes, incentives and support, along with local democratic leadership to improve the public’s health (NHS England 2014, Five Year Forward View).

3.3. The public sector, however, has struggled to prioritise interventions that maintain and improve public health. While these decisions can be partly attributed to the long-term nature of these problems and the need to make trade-offs in the short-term, they also
stem from a dominant treatment paradigm within the NHS. The NHS, as described in the Five Year Forward View, has yet to maximise the potential that a population health approach can offer, although exceptions such as national screening and vaccination programmes exist. Its overall strategy and budgetary arrangements to date have not been compatible with the more holistic and longer-term approach needed for population health. A focus on population health will be integral to the success of the NHS and the health and wellbeing of the UK over the next 10 years. Trade-offs are intrinsic to health and health care, and there are several other factors that will be integral to this success over the medium to long-term, but the NHS cannot afford to sacrifice transformation for tomorrow for efficiency today (Health Foundation 2015, Shaping the Future).

3.4. Improving our population health is critical to the long-term sustainability of our health system. As the chart shows, more than £1 in every £5 of NHS commissioning spending is estimated to be associated with ill health that is attributable to poor diet and obesity, physical inactivity smoking and alcohol.

![NHS budget 2006/07, £98bn (2015/16 prices)](image)

Source: Scarborough et al. 2011

3.5. Furthermore, it is increasingly recognised that people’s health is an outcome of a complex web of social, cultural, environmental, biological and psychological influences. Individual interventions to promote healthy behaviours, or curb unhealthy ones, need to be considered within this wider set of influences and for the desired impact to be realised there needs to be alignment of policies across the private and public sector.

International comparisons

3.6. The challenges of using summary international indicators to compare health and health care are well known (QualityWatch, 2015). Importantly, international indicators are better at framing questions and initiating a debate than producing definitive judgements. Using different methods to collect and analyse data, and comparing
performance across different comparator countries can produce different results. Nevertheless, a number of reports have highlighted that the health of the UK population compares poorly with other countries, including those in the EU15 as well as the broader group of OECD countries and the attached table (appendix 1) shows where the UK ranks on various measures compared to the EU15 countries.

3.7. The UK has high rates of smoking, harmful alcohol consumption and obesity (OECD, 2015). The UK population is amongst the most overweight in both the EU15 and the OECD, with one in four British adults being obese. This may be partly due to the UK being one of several countries where obesity data is based on measured height and weight, which results in higher reported prevalence than in countries that use self-reported data. The number of smokers is falling, but one in five adults still smoked in 2013. Levels of alcohol consumption in the UK are above the OECD average and have increased during the last 30 years. Our QualityWatch report also highlights that, in England, the heaviest-drinking 20% of the population drink almost two thirds of all alcohol consumed. The report called for urgent action to tackle these as important risk factors for some of the leading causes of premature mortality, such as cardiovascular disease, cancer and diabetes.

3.8. The Global Burden of Disease Study also highlights that the UK’s leading risk factors for premature death are linked to lifestyle – in particular, dietary risks, tobacco smoking and high blood pressure (Institute for Health Metrics and Evaluation, 2013). The UK’s performance compared to others in tackling such risk factors presents a mixed picture.

3.9. The oft-cited Commonwealth Fund report in 2014 ranked the UK as having the best overall health system in the world but also suggested the extent to which our citizens have healthy lives as lagging behind other developed countries. The report looked at 11 countries and found the UK among the lowest across all of the three measures, namely: mortality amenable to health care (ranked 9th overall), infant mortality (8th overall) and healthy life expectancy (9th overall). In some respects, the UK performs well. Access to health care in the UK is good, with unmet needs for medical and dental care below the OECD average and low waiting times for elective care.

3.10. Recent analysis by our QualityWatch research programme, joint with the Nuffield Trust, found that the UK also performs very well on cancer screening. Between 2000 and 2012, the UK maintained stable and very high breast cancer screening rates, with an average of 76% of 50-to-69-year-old women being screened. Only the Netherlands (80.1%) and Finland (84.8%) had higher breast cancer screening rates than the UK in 2011. Screening can contribute to prevention by detecting pre-cancerous stages, and to the early detection and treatment of cancer, and therefore to longer survival and reduced mortality.

3.11. Breast cancer mortality in the UK has been declining since the early 2000s: it fell from 37.7 deaths per 100,000 women in 2001 to 30.4 deaths per 100,000 women in 2010. However, survival rates for breast, cervical and colorectal cancers in the UK are the worst of the EU15 countries that submit data to the OECD and among the worst in the larger group of OECD countries (OECD, 2015).

3.12. The UK has one of the highest vaccination rates for influenza in the OECD as in 2012 75.5% of people over the age of 65 were vaccinated, exceeding the WHO target of 75% for the first time. Diphtheria, tetanus and pertussis (DTP) vaccinations
and measles vaccinations are part of the UK’s routine childhood vaccination programme and are considered to provide safe and effective protection against these diseases. Since 2008, the UK has improved significantly on the DTP vaccination rate: this increased from 92% in 2008 to 97% in 2012, although it dropped to 96% in 2013. Belgium, France and Greece – together with many other OECD countries (e.g. the Czech Republic, Hungary and Poland) – have reached even higher vaccination rates, with 99% coverage.

3.13. Over recent years, more and more importance has been given to controlling antibiotic prescribing in light of increasing antibiotic resistance. Antibiotic resistance is one of the most important threats to global safety worldwide and is driven by the over-use of antibiotics and inappropriate prescribing (Public Health England, 2014). Since 2000 in the UK, the volume of antibiotics prescribed in primary care per day has increased. It rose from 14.3 defined daily doses in 2000 to 19.4 defined daily doses in 2012. The UK performs better than many countries but lags behind Canada, Germany, Sweden and the Netherlands – the last of these being the best performer.

4. Analysis

Public health spending

4.1. From 1 April 2013, each upper-tier local authority in England has been under a duty to take such steps as it considers appropriate for improving the health of the people in its area. This is a broad power and the services that local authorities would be expected to commission might include local programmes to address obesity, smoking cessation, substance misuse services and public mental health services for example suicide prevention programmes. In addition, local authorities are mandated to provide certain services which include the provision of open access sexual health services, health check assessments for those aged 40-74, the national child measurement programme and from October 2015, local authorities took on commissioning responsibilities for the 0-5 health visiting service.

4.2. The Comprehensive Spending Review announced that reforms to the public health system would deliver annual real terms savings of 3.9% over the next five years.

4.3. Local authority public health budgets have recently been reduced by £200m. In addition to the impact on the population’s health, disinvestment in public health risks harming the health and care system as a whole and may increase cost pressures on the NHS. Improving the health and wellbeing of the population relies on an effective public health system, as does delivering the Five Year Forward View.

Opportunities presented by devolution

4.4. The current devolution agenda presents an opportunity for public health (already devolved) to become more prominent within local government agendas. Local government becoming more involved with health care adds impetus to the case for prevention (as they will be directly involved in meeting demand for health care that could be avoided). For example, there are opportunities to take public health into account in its decisions about the provision and commissioning of a range of public services such as skills and employment, which have potential to improve health.
4.5. There is, however, a historical trend of public health being viewed as a secondary function to other aspects of health, such as acute care. In an era of financial pressure on the NHS and a depleted public health budget, it will take very strong leadership and vision for public health to be prioritised. Galvanising the enthusiasm and momentum that devolution deals bring with them to form new relationships between different public services will be critical in making the most of the opportunity devolution presents to improve health.

4.6. Devolution also allows areas to experiment with different approaches to improving their population’s health. To allow learning from different areas, it is important that we understand the approaches taken and outcomes achieved. The Health Foundation, in collaboration with the Greater Manchester Collaboration for Leadership in Applied Health Research and Care, has commissioned the University of Manchester to work alongside policymakers, system leaders and stakeholders in Greater Manchester to understand their process of policy development. The team will describe and analyse the governance, accountability, and organisational forms which develop, as well as mapping changes in the way services are delivered. These learnings will then be disseminated both locally and nationally.

5. Further work

5.1. We are extending the focus of the Health Foundation to look more broadly at the determinants of health, and influence how decision makers think about the health of people living in the UK and what they can do to support healthier lives. For too long, discourse about health has been dominated by the access and availability of health care services. There is now broad consensus that the real determinants of health largely sit outside of health care and that a wider set of resources will need to be mobilised to maintain and improve health. With preventable illness widespread and health inequalities deep rooted, a radical update is needed to how governments approach the health agenda. By looking at best practice and evidence from the UK and abroad we plan to identify and support approaches that can help people to maintain good health and prevent illness. Over the coming months our strategy in this area will be developed and we will start to publish initial outputs.

5.2. As part of its inquiry the committee may want to explore work of The Robert Wood Johnson Foundation, which is leading in the United States to build a culture of health. The foundation recently published an Action Framework to reflect its vision of health and well-being, along with series of interdependent Action Areas, each comprised of a set of corresponding drivers and measures outlined in the table below.

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Proposed measures</th>
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<tbody>
<tr>
<td>Making Health a Shared Value</td>
<td>Measured by indicators such as the percentage of people who strongly agree that health is influenced by their peers and their communities and the percentage who indicate they have adequate social support from family and friends</td>
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<tr>
<td>Fostering Cross-Sector Collaboration to Improve Well-Being</td>
<td>Denoted by measures like the number of local health departments that collaborate with community organizations and employers who promote better health in the workplace.</td>
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<tr>
<td>Creating Healthier, More Equitable Communities</td>
<td>using measurements such as the number of grocery stores, farmers’ markets, and safe sidewalks in communities; the ratio of children attending preschool; and the affordability of housing</td>
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<tr>
<td>Strengthening</td>
<td>gauged by measures such as the percentage of people served</td>
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<td><strong>Integration of Health Services and Systems</strong></td>
<td>by a comprehensive public health system and the percentage of physicians sharing electronic data with other clinicians, health systems and patients</td>
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